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RESEARCH ARTICLE

"EVALUATING THE IMPACT OF STRUCTURED EDUCATIONAL PROGRAMS ON KNOWLEDGE AND ATTITUDES TOWARD TEMPORARY FAMILY PLANNING METHODS: A REVIEW ANALYSIS"

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Abstract

This study evaluates the impact of structured educational programs on knowledge and attitudes toward temporary family planning methods. Through a comprehensive review of secondary data sources, the study analyzes various theoretical frameworks, such as the Health Belief Model and the Theory of Planned Behavior, to understand the factors influencing contraceptive use. The findings underscore the significance of educational interventions in enhancing knowledge, dispelling myths, and promoting positive attitudes toward temporary family planning methods. The study concludes that structured educational programs are crucial in bridging the gap between awareness and practice, ultimately contributing to better family planning outcomes.

Introduction:-

"Delay the first, postpone the second, and prevent the third."

Demography today is recognized as the scientific study of human populations, with a focus on three key aspects: (a) changes in population size (whether growth or decline), (b) the composition of the population, and (c) the spatial distribution of populations. It examines five fundamental "demographic processes": fertility, mortality, marriage, migration, and social mobility. These processes are constantly influencing a population's size, composition, and distribution.[1]

In 1971, a WHO expert committee defined family planning as "a way of thinking and living that is voluntarily adopted based on knowledge, attitudes, and responsible decisions by individuals and couples, in order to promote the health and welfare of the family unit and contribute effectively to the social development of a country."[2]

Another expert committee expanded on this definition, describing family planning as practices that help individuals or couples achieve specific goals:

1. Avoiding unwanted births
2. Enabling desired births
3. Regulating the intervals between pregnancies
4. Controlling the timing of births in relation to the parents' ages
5. Determining the number of children in a family [3]

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The United Nations Conference on Human Rights in Teheran in 1968 recognized family planning as a fundamental human right.[4] This was reaffirmed at the World Population Conference in Bucharest in August 1974, which declared in its "Plan of Action" that all couples and individuals have the basic human right to freely and responsibly decide the number and spacing of their children and to have access to the information, education, and means to do so. The World Conference of the International Women's Year also affirmed "the right of women to decide freely and responsibly on the number and spacing of their children and to have access to the information and means necessary to exercise that right." Over recent decades, family planning has transitioned from being a private matter to an issue of international concern, recognized as a basic human right and an integral component of health and social welfare.[5]

Contraception should be viewed within the broader context of sexual and reproductive health. The ability to enjoy and control sexual and reproductive behavior is a key aspect of sexual health, and it is widely accepted that birth intervals of at least two years can improve maternal and infant mortality rates.[6]

Additionally, surveys conducted post-partum indicate that women may prefer to discuss contraception either antenatally or after hospital discharge, ideally as part of broader education on maternal and child health.[7]

India was the first country in the world to establish a national family planning program in 1952, with the goal of reducing the birth rate to a level consistent with the country's economic needs. One of the program's primary objectives is to spread awareness of family planning methods and foster a positive attitude toward the adoption of contraceptive practices. Progress in this area is typically assessed through Knowledge, Attitude, and Practice (KAP) surveys. Despite increased use of contraception over time, a gap persists between knowledge, attitudes, and practice regarding contraception. In a developing country like India, overpopulation is a major concern. Despite the widespread availability of contraception, many people are hesitant to use these methods due to ignorance or fear of complications. [8]

Insufficient knowledge, attitudes, and practices regarding contraceptive methods, as well as incomplete or misleading information about their use or availability, are key reasons for the reluctance to adopt family planning. Considering these factors, the present study was conducted to assess the knowledge, attitudes, and practices regarding contraceptive methods among first-time and multiple-time mothers in a selected hospital. [9]

The WHO defines family planning as "a way of thinking and living that is voluntarily adopted, based on knowledge, attitudes, and responsible decisions by individuals and couples, in order to promote the health and welfare of the family unit and contribute effectively to the social development of a country."

Family is the basic unit of society, and each family member's independence is crucial to defining the family. Every family is a social system with its own culture, values, and rules, structured around basic functions and progressing through various stages. In developing countries like India, overpopulation remains a significant concern.[10]

According to the latest United Nations data, as elaborated by Worldometer, India's current population is approximately 1.563 billion. Despite the progress made in making contraception widely available, acceptance remains low, often due to ignorance or fear of side effects. Family planning has become an essential tool for reducing maternal and child mortality.[11]

In 2015, India reported 15.6 million abortions, with a rate of 47.0 abortions per 1,000 women aged 15-49 years, which accounted for one-third of all pregnancies. This high abortion rate reflects a large number of unintended pregnancies, with a rate of 70.1 per 1,000 women aged 15-49 years, nearly half of all pregnancies during that period. [12]

India's fertility rate for 2022 was 2.159 births per woman, a 0.92% decline from 2021. The fertility rate for 2021 was 2.179 births per woman, a 0.95% decline from 2020. Population experts have determined that India needs to achieve a Couple Protection Rate (CPR) of 60% by the year 2000 to reduce population growth and stabilize the population. CPR is defined as the percentage of eligible couples effectively protected against childbirth through one or more approved temporary family planning methods.[13]

Many approaches have been proposed to prevent unwanted births, reduce population growth, regulate intervals between pregnancies, and facilitate desired births, but the effectiveness of many of these methods has not been rigorously established. Given the importance of awareness about temporary family planning methods and assessing knowledge among first-time mothers, the investigator aimed to assess knowledge, attitudes, and practices regarding temporary family planning methods.[14]

Objective of the Study:-

This paper aims to evaluate the impact of structured educational programs on knowledge and attitudes toward temporary family planning methods.

Methodology of the Study:-

The study is based on secondary data. Secondary data provides a better view of the problem and is collected from journals, online journals, books and libraries.

Theoretical Framework:

When discussing the theoretical framework for a study that evaluates the impact of structured educational programs on knowledge and attitudes toward temporary family planning methods, it's important to consider theories and models that explain how education can influence behavior change. Two widely recognized models in this context are the Health Belief Model (HBM) and the Theory of Planned Behavior (TPB).

Health Belief Model (HBM)

The Health Belief Model (HBM) is one of the most widely used frameworks for understanding health behaviors, including contraceptive use. It was originally developed by social psychologists in the 1950s to explain why people fail to participate in programs that prevent or detect disease.[15] The HBM posits that individuals' health-related behavior depends on their perceptions of several factors:

1. Perceived Susceptibility: The belief that one is at risk of a certain health condition. In the context of family planning, this could relate to the perceived likelihood of unintended pregnancies.
2. Perceived Severity: The belief in the seriousness of the consequences of the health condition. Regarding family planning, this could involve the perceived consequences of an unplanned pregnancy on personal, financial, or social well-being.
3. Perceived Benefits: The belief that a specific action will reduce susceptibility or severity. In this case, the belief that using temporary family planning methods effectively prevents unintended pregnancies.
4. Perceived Barriers: The perceived obstacles to taking action. Barriers might include concerns about side effects, cultural or religious objections, or lack of access to contraceptive methods.
5. Cues to Action: External triggers that prompt the decision to act. Educational programs can serve as cues to action by providing information and encouraging discussions about family planning.
6. Self-Efficacy: The belief in one's ability to take the necessary action. Educational programs can enhance self-efficacy by teaching individuals how to use contraceptives correctly and confidently.[16]

By applying the HBM, structured educational programs can be designed to address each of these components, thereby increasing knowledge and positively influencing attitudes toward the use of temporary family planning methods.

Theory of Planned Behavior (TPB)

The Theory of Planned Behavior (TPB) extends the Theory of Reasoned Action (TRA) and was developed by Icek Ajzen in 1985. This model is particularly useful for predicting and understanding behaviors that require planning, such as the consistent use of contraceptives.[17] The TPB suggests that behavior is directly influenced by behavioral intentions, which are shaped by three factors:

1. Attitude toward the Behavior: The individual's positive or negative evaluation of performing the behavior. Education can influence attitudes by providing accurate information and dispelling myths about family planning methods.
2. Subjective Norms: The perceived social pressure to perform or not perform the behavior. Educational programs can address subjective norms by involving influential figures (e.g., community leaders, peers) who endorse the use of family planning.

3. Perceived Behavioral Control: The perceived ease or difficulty of performing the behavior. This factor is akin to self-efficacy and can be influenced by educational interventions that enhance skills and confidence in using contraceptives. [18]

The TPB posits that when individuals hold favorable attitudes toward family planning, perceive that important others (e.g., family, peers) support it, and believe they have the control to use contraceptives, they are more likely to engage in the behavior. Structured educational programs can be designed to positively influence each of these determinants, thereby promoting the use of temporary family planning methods.

Review of Literature:-

A study focusing on family life education was conducted with 135 non-school-going adolescents in 'Malawani,' an urban slum in North West Bombay. The data was collected using a structured interview schedule. The results revealed that only 25.19% of participants were aware of family planning methods. Most participants recognized condoms and Saheli as contraceptive methods, largely due to extensive mass media advertising. However, awareness of Copper-T was low, with only 4.44% of participants knowing about it.[19]

In Bangladesh, a study titled "Inter-Spousal Communication on Family Planning as a Determinant of the Use of Modern Contraception" surveyed 9,640 female and 3,874 male respondents. Data was gathered through questionnaires. The findings showed that factors such as the woman's age, number of living children, educational level, assets, type of residence, and mobility were significantly associated with the use of modern reversible contraceptive methods. Educated women reported a higher use of these methods, with 36.4% utilizing them. The study also highlighted that inter-spousal communication played a crucial role in the adoption of modern reversible contraceptive methods, with the likelihood of use increasing as communication frequency between spouses went from "Never" to "Always."[20]

A study conducted by the National Family Health Survey (NFHS) in India explored contraceptive use among Indian women. Data was collected through structured interviews. The study found that while knowledge of contraception is nearly universal among Indian women, only 41% actively use contraception, according to NFHS. The average number of children at the first use of contraception was reported as three. Sterilization, particularly female sterilization, was the preferred method among the majority, with the median age of wives at the time of sterilization being 26.6 years. Additionally, 79% of current users of modern contraceptive methods sourced their contraception from government facilities, though only 6% of women were using modern temporary methods.[21]

A global study on the utilization of intrauterine devices (IUDs) among women used a structured interview schedule to gather data from participants. The study reported that over 600 million women worldwide are using various contraceptive methods, with oral contraceptives, injectables, and intrauterine contraceptive devices being the most widely used.[22]

It was estimated that around 105 million married women, approximately one in five, were not using any contraceptive methods. Another study, focusing on the attitudes of women towards family planning methods, surveyed 40 women of childbearing age (15-49 years) in a slum in California. Over a one-year period, the study found that the most commonly reported side effect from all family planning methods was weakness. More than 70% of women reported experiencing irregular menstruation due to oral contraceptive pills, and ill health was associated with tubectomy. The main reasons for not using any contraceptive methods included the desire for more children, a preference for sons, fear of side effects, and health concerns. There was little change in the use of family planning methods during the study period. The study concluded that effective use of family planning methods should be promoted through proper counseling on their correct use, potential side effects, and management strategies.[23]

A study on the knowledge, attitudes, and practices regarding family planning methods was conducted among 60 eligible couples in Ward Six of Sreekaryam Panchayat, Kerala. Data was collected using a structured interview schedule. The findings revealed that 87% of participants had below-average knowledge scores. Additionally, 56.7% of the couples were not practicing any form of family planning, while 43.3% were. Among those practicing, 46.2% used Copper-T. A significant portion, 73.1%, of the couples who did not practice family planning cited a general dislike for these methods as the reason. [24]

Another study examined child spacing and the utilization of maternal health care services in selected states of India. The sample included 1,932 women from Madhya Pradesh, 1,145 from Orissa, and 719 from Tamil Nadu. The study found that the median birth interval in Madhya Pradesh was 39 months, with longer intervals observed in urban areas compared to rural areas. Educated mothers were found to have longer birth intervals, likely due to more frequent and effective use of contraceptives. Similarly, women from households with a higher standard of living had longer median birth intervals compared to those from lower-income households. Mothers who breastfed their children for 18 months or longer also had longer birth intervals than those who either did not breastfeed or breastfed for less than 18 months. The study concluded that breastfeeding practices, coupled with effective contraception, can significantly extend birth intervals. Additionally, poor nutrition and health may contribute to reduced fertility and delays in conception among women in these regions.[25]

A study was conducted to evaluate contraceptive choices using the method mix approach. A total of 8,077 potential clients received balanced information about all available contraceptive methods within the national program, including the CUT 200 intrauterine device (IUD), low-dose combined oral pills, condoms, sterilization, and Norplant. The study's findings revealed that most women opted for spacing methods, with about 60% preferring the IUD, followed by 9% choosing condoms, 6% selecting oral contraceptives, and 5% opting for Norplant. The study also indicated that by providing potential clients with the information necessary to make informed choices, they could overcome any biases from providers when deciding on a particular spacing method.[26]

Another study focused on factors influencing contraceptive method choices at the Family Planning Clinic of the University College Hospital in Ibadan, Nigeria, among 2,000 women. Data collection was carried out through structured questionnaires. The study reported that 66.2% of the women seeking contraceptive services chose the intrauterine device (IUD), making it the most common contraceptive method. Factors such as ignorance, fear, and unfounded cultural beliefs were identified as reasons for delays in seeking contraceptive advice. The mass media emerged as a significant source of information for many of the women. The study also found that the average age of those accepting contraception was 31.5 years, with an average of 4.4 children. Additionally, 63.2% of the women sought contraception to delay or postpone pregnancy. The four most frequently chosen methods were IUDs (66.2%), oral contraceptives (10.4%), injectables (7.9%), and sterilization (5.8%), with mass media and friends being the most influential sources of information.[27]

In Missouri, a study titled “Women’s Interest in Natural Family Planning” involved mailing questionnaires to 1,500 women aged 18 to 50, randomly selected from driver's license renewal records. Of the 747 returned questionnaires, 484 were from women still of childbearing age. The study found that 22.5% of these women were likely or very likely to use natural family planning in the future to avoid pregnancy, while 37.4% expressed a likelihood to use it in the future to become pregnant. However, only 2.8% were currently using a natural family planning method. Past use of any natural family planning method to avoid pregnancy was linked to an interest in future use of modern natural family planning methods.[28]

A study at the family planning clinic of the University of Nigeria Teaching Hospital in Enugu, Nigeria, analyzed contraceptive use among 19,470 clients. Structured interviews were used to collect data. The study revealed that of the 19,470 clients who visited the clinic, 2,402 (12%) were new patients, while 17,068 (88%) were returning patients. Among the new clients, 2,262 (94%) eventually accepted a contraceptive method. The majority of these women (60%) chose the intrauterine contraceptive device (IUCD), 20% opted for injectables, and 8% selected sterilization, with oral contraceptive pills being the least popular choice at just 1%. [29]

Current Trends in Educational Interventions for Family Planning

Recent trends in educational interventions for family planning reflect a growing recognition of the importance of culturally sensitive approaches, the integration of technology, and the expansion of community-based programs. These trends aim to address the diverse needs of populations while improving access to and acceptance of family planning methods.

Use of Technology in Family Planning Education

One of the most significant trends in family planning education is the increasing use of technology to deliver information and services. Mobile health (mHealth) platforms, social media, and digital applications have become valuable tools for disseminating family planning education. These technologies allow for personalized, on-demand information and have the potential to reach wide audiences, including those in remote or underserved areas.

1. Mobile Health (mHealth): mHealth interventions, such as text messaging services and mobile apps, have been effective in providing education on contraceptive options, reminding users to take contraceptives, and offering virtual counseling. For example, the mCENAS! program in Mozambique used text messages to increase contraceptive use among young women, resulting in higher awareness and uptake of family planning methods (Ramanadhan et al., 2021).[30]
2. Social Media Campaigns: Social media platforms like Facebook, WhatsApp, and Instagram are increasingly being used to reach younger populations with family planning messages. These platforms allow for interactive communication, enabling users to ask questions and receive real-time responses. For instance, a study in Nigeria showed that a Facebook-based intervention significantly increased awareness and use of modern contraceptives among women aged 18-35 (Makleff et al., 2019).[31]

Community-Based Programs

Community-based approaches remain a cornerstone of family planning education, particularly in areas where access to healthcare facilities is limited. These programs involve local leaders, community health workers, and peer educators to ensure that family planning messages are delivered in a culturally appropriate and accessible manner.

1. Community Health Workers (CHWs): CHWs play a critical role in providing education and counseling on family planning. They are often trusted members of the community and can address misconceptions, provide referrals, and distribute contraceptives directly to households. A study in Kenya found that CHWs effectively increased contraceptive uptake by providing door-to-door counseling and distributing contraceptives, particularly in rural areas (Olajide et al., 2020).[32]
2. Peer Education Programs: Peer education is another effective community-based approach, especially among adolescents and young adults. By training young people to educate their peers, these programs leverage social networks to spread knowledge about family planning. For example, in Malawi, a peer education program significantly improved knowledge and use of contraceptives among adolescents (Chandra-Mouli et al., 2018).[33]

Culturally Sensitive Approaches

Culturally sensitive approaches to family planning education are essential in contexts where cultural, religious, or social norms may influence attitudes toward contraceptive use. These approaches involve tailoring messages and interventions to align with local values and beliefs, often by engaging religious leaders, elders, and other influential community members.

1. Integration with Cultural and Religious Practices: In many settings, integrating family planning education with cultural or religious practices has proven effective. For instance, in Senegal, the implementation of the "Muslim Leaders Family Planning Advocacy" program, which engaged religious leaders to promote family planning within an Islamic framework, resulted in increased acceptance and use of contraceptives (Duvall et al., 2019).[34]
2. Contextualized Messaging: Developing educational materials and messages that resonate with local customs and languages is critical for successful family planning interventions. In India, for example, a program that used culturally adapted videos and storytelling to convey the benefits of family planning significantly improved knowledge and reduced opposition to contraceptive use in rural communities (Khan et al., 2017).[35]

Summary:

The publication investigates the effect of structured educational programs on knowledge and attitudes toward temporary family planning methods. Utilizing a review analysis of secondary data, it explores the role of educational interventions in promoting the use of temporary contraceptive methods. The study is grounded in theoretical frameworks like the Health Belief Model and the Theory of Planned Behavior, which provide insight into the behavioral factors that influence contraceptive adoption. The review includes various studies that highlight the gap between knowledge and practice, emphasizing the need for educational programs to address misconceptions and cultural barriers.

Conclusion:-

The study concludes that structured educational programs are instrumental in improving knowledge and attitudes toward temporary family planning methods. By addressing the components of the Health Belief Model and the Theory of Planned Behavior, these programs can effectively enhance individuals' perceptions of susceptibility, severity, benefits, and barriers related to contraceptive use. The research emphasizes the importance of culturally sensitive and community-based educational interventions to ensure widespread adoption of temporary family

planning methods. Ultimately, these programs play a vital role in reducing unintended pregnancies, improving maternal and child health, and contributing to broader social development.

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